CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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CHAPTER VI

UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R. Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of

the overpayment is extrapolated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

UTILIZATION REVIEW OF THE PROVIDER RECIPIENT RECORD AND HOME VISIT

The purpose of utilization review is to determine whether services have been provided according to regulations and policy, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipient are protected and addresses the quality of care, appropriateness of care, level of care, and individual cost-effectiveness. DMAS analysts conduct utilization review of the documentation submitted by the provider, which shows the recipient's needs and available social supports and via on-site quality assurance reviews of the provider's recipient records, interviews with provider staff and recipients conducted in the recipient's home, the provider, and via telephone call and written communication.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues that, if not corrected, might result in the termination of the provider contract will be presented to the provider in writing.

CONTENTS OF REVIEW

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to a population in need of nursing facility level of care. Information used by DMAS to make this assessment includes DMAS desk review of the documentation submitted by the provider, as well as on-site review of the provider's files and interviews with staff and with recipients on visits to recipients' homes and via responses to quality assurance survey letters. DMAS bases its assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

1. Recipients served by the provider meet the program's target population. The services facilitator has a responsibility to be aware of the criteria for this program and to evaluate accordingly, on an ongoing basis, recipients' appropriateness for services. The CD services facilitator must terminate services, using the procedures outlined in Chapter V, for any recipient whose condition does not meet the target population criteria.

2. Services being rendered meet the recipient's identified needs and are within the program's guidelines. The services facilitator is responsible for continuously assessing the recipient's needs through visits made by the CD services facilitator and communication between the CD services facilitator and other provider staff. The Plan of Care must be revised in accordance with any substantial change in the recipient's condition, and the recipient's record must contain documentation of any such change. This also includes the provider's responsibility to identify and make referrals for any other services which the recipient requires to remain in the home setting (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. The services facilitator documentation must support all services billed to DMAS.

4. Services are of a quality that meets the health and safety needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the recipient and the attendant, and between the recipient and the CD services facilitator who is responsible for the oversight of the plan of care. The quality of care is best assessed through communication with recipients. Some of the elements included in quality of care are:

    - Consistency of care;
    - Continuity of care;
    - Adherence to the Plan of Care; and
    - Health and safety needs of the recipient.

DMAS will review the provider's performance in all the program goal areas to determine the provider's ability to achieve high quality of care and conform to DMAS policies. DMAS is responsible for providing feedback to the provider regarding those areas that may need improvement. During reviews, the analyst will review recipient files and conduct home visits to assess the quality of care and continued appropriateness of consumer-directed personal attendant services.

DMAS will communicate in writing with all providers following the desk and on-site reviews to identify strengths and any areas in which improvement is needed.

DMAS will visit a sample of recipients (clients) in their homes to review the appropriateness, quality, and level of care received. If the Plan of Care is found to be inadequate, DMAS may change the hours or level of care. DMAS will evaluate the client's condition, satisfaction with the service, and appropriateness of the current Plan of Care.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services which have been provided and which are covered by the DMAS Consumer-Directed Personal Attendant Services Program, and to ensure that the appropriate patient pay amounts, if any, have been applied. Any paid provider claims that cannot be verified at the time of utilization review cannot be considered a valid claim for services provided. Services that have billed and reimbursed by DMAS must be supported by the appropriate documentation in the recipient's file.

DMAS will send a letter of utilization review findings to the provider; attached to the letter will be a billing problem form listing any incorrect billings found at the time of the utilization review, and the corrective action the services facilitator needs to take.

The provider should submit an adjustment as indicated within 30 days of the receipt of this form. If an adjustment is not received within 30 days, a reminder will be sent to the provider and an additional 30 days will be allowed for the adjustment of overpaid funds. If, at the end of this period, no adjustment has been made, DMAS will initiate a demand letter that requires the adjustment of overpaid funds to be made within 21 days. Failure to respond to this demand letter will result in DMAS recovery of funds from future provider remittances. Referral to the DMAS Post-Payment Review Section may be made.

Section 32.1-325.1 of the Code of Virginia requires that DMAS collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. Unless a lump sum cash payment is made, interest will be added to the declining balance at the statutory rate pursuant to § 32.1-313 of the Code of Virginia. Repayment and interest will not apply pending appeal.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

DOCUMENTATION REQUIRED - RECIPIENT RECORD

The CD services facilitator shall maintain a record for each recipient. <u>These records must be separated from those of other services, such as companion or home health services</u>. These records shall be reviewed periodically by DMAS staff. At a minimum, these records shall contain:

- The Uniform Assessment Instrument (UAI); the Nursing Home Pre-Admission Screening Authorization signed by all members of the Screening Committee (DMAS-96); the Screening Team Plan of Care (DMAS-97); the Questionnaire used to Assess a Person's Ability to Independently Manage Personal

Attendants (DMAS-95 Addendum); all CD services facilitator Plans of Care (DMAS-

97B), and all DMAS-122's. The current and prior DMAS-122s, for at least the last six months of services must be in the client's record. The "Exhibits" section of Chapter IV contains copies of these forms.

- All Plans of Care.

- The initial assessment by the CD services facilitator completed prior to or on the date services are initiated and filed in the provider record within five working days from the date of the visit. (See Chapter IV for the content of the initial assessment.) The example standardized form may be used to document the initial visit. (See the "Exhibits" section at the end of Chapter IV for a copy of this form.)

- CD services facilitator notes must be in the recipient's record within five days of the last supervisory visit made to the recipient. Any visit not documented and present in the recipient's record will be considered as not having been made. CD services facilitator notes must reflect all significant contacts with the recipient and document that the CD services facilitator has made a supervisory visit in the recipient's home at least every 30-90 days following the CD services facilitator's initial comprehensive visit. The CD services facilitator's initial comprehensive visit in the recipient's home must also be documented. The CD services facilitator's documentation must include the observations of the recipient made during the visits, as well as any instruction or counseling provided to the attendant on behalf of the recipient. The CD services facilitator's notes must also clearly document that he or she has discussed with the recipient the appropriateness and adequacy of service. Recipient satisfaction with the services should be documented, as well as all requirements for CD services facilitators and documentation found in Chapter II of this manual.

- All CD services facilitator notes pertaining to the required routine visits must be on file within five working days of the date of the visit.

- All CD services facilitator notes regarding contacts made between the CD services facilitator's visits. This includes the documentation of contacts with recipients or support system when services cannot be delivered. Other contacts may be with the family, the physician, DMAS, WVMI, or other professionals. All notes must be filed in the recipient's file within five working days of the contact. White-out must not be used to make corrections to the file.

- A copy of all Recipient Assessment Reports (DMAS-99B) submitted to DMAS.

- All correspondence between the provider, the recipient, DMAS, and WVMI.

- Contracts signed by the recipient which document the recipient's choice of consumer-directed personal attendant services, choice of the services facilitator, and acknowledgment of rights, risks, and responsibilities associated with the program.

- Reassessments made during the provision of services.

- All training provided to the personal attendant or attendants on behalf of the recipient.

- Outline and checklist for Consumer-Directed Recipient Comprehensive Training. This form must be completed with signatures and dates, and performed prior to the hire date of the personal attendant.

- The attendant's personnel file must contain a statement from the recipient, which states the personal attendant meets the minimum qualifications outlined in Chapter II. The file must also contain the original criminal records check.

- The CD services facilitator's personnel file must verify that the CD services facilitator meets the minimum qualifications outlined in Chapter II of this manual.

- Documentation to support billing of any management training conducted by the services facilitator.

EXIT CONFERENCE

Following the analyst's review of the records and home visits, the analyst will meet with the appropriate provider staff to discuss the findings from the reviews. The provider must provide appropriate staff (as requested by the analyst) for this meeting.

The provider will be informed of the number of records reviewed, number of home visits made, recommendations regarding a level of care change, recommendations regarding changes in the care plans, along with other information regarding the provision of services. The analyst will send a letter to the provider verifying that the review was conducted and describing the findings from the review.

DMAS expects the provider to utilize the findings of the utilization review analyst to comply with regulations, policies, and procedures in the future. Records that have been reviewed should not be altered to meet the compliance issues.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and as-

sistance. Any issues which, if uncorrected, might result in the termination of the provider contract will be presented in writing.

RETRACTABLE ITEMS FOR UTILIZATION REVIEW

1. Services began prior to authorization date on DMAS-96.	**12 VAC 30-120-Part VIII §2 C 7.** Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the NHPAST.
2. No initial comprehensive visit made by the CD services facilitator prior to the initiation of attendant services.	**12 VAC 30-120-Part VIII §4 B 5.a.** The CD services facilitator must make an initial comprehensive home visit to develop the POC with the recipient and provide management training.
3. CD services facilitator did not make routine visits every 30-90 days.	**12 VAC 30-120-Part VIII §4 B 5.a.** The CD services facilitator will continue to monitor the POC on an as needed basis, not to exceed a maximum of one routine on-site visit every 30 days or a minimum of one routine on-site visit every 90 days per recipient.
4. No re-evaluation completed every 6 months.	**12 VAC 30-120-Part VIII §4 5.b.** A reevaluation of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months.
5. Facilitator billed DMAS for a a criminal record check on the attendant, but there is no evidence of a criminal check in the recipient's/attendant's file	**12 VAC 30-120-Part VIII §4 6.** The CD services facilitator will submit a criminal record check pertaining to the personal attendant on behalf of the recipient and report findings of the criminal record check to the recipient.
6. CD services facilitator does not meet the qualification criteria	**12 VAC 30-120-520.** It is preferred that the individual employed by the services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. In addition, it is preferable that the individual have two years of satisfactory work experience in the human services field working with persons with severe physical disabilities or the elderly.
7. Two subsequent visits were not made within 60 days of initial visit.	**12 VAC 30-120-Part VIII §4 B 5.a.** The facilitator must conduct two on-site visits within 60 days of the initiation of care or the initial visit.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action, which includes the termination or suspension of the participation agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days from the date of the notice to submit information for written reconsideration, and will have 30 days to request an informal conference and a formal evidentiary hearing once the reconsideration decision is rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act. Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

REQUEST FOR CORRECTIVE ACTION

Failure to comply with DMAS regulations, policies, or procedures may result in a corrective action letter to the provider. A corrective action letter cites to the provider those areas that have been found to be out of compliance and requests that a corrective plan of action be submitted to DMAS within a specified time-period. This plan must address all the areas cited in the corrective action letter with time frames indicated within which corrective action will be taken. The provider will be monitored closely during subsequent utilization reviews. If improvement is not made in areas cited, DMAS may move to terminate the provider's contract.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.